TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
Ohio Security Insurance Co

MFDR Tracking Number
M4-17-2848-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 25, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: $1,084.91

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We base our payments on the Texas Fee Guidelines and the Texas Department of Insurance Division of Workers' Compensation Acts and Rules. This is not a network claim."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 14 – 15, 2016	96361, 96366, 26356, G0237, 94640, G0237, 96374	$1,084.91	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - W3 – Request for reconsideration

- 193 – Original payment decision is being maintained

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule that applies to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking and additional $1,048.91 for outpatient hospital services provided from December 14 through 15th, 2016. The insurance carrier denied disputed services with claim adjustment reason code 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated" and P12 – Workers' compensation jurisdictional fee schedule adjustment."

   28 Texas Administrative Code §134.403 (d) states in pertinent parts,

   > (d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided

   The application of the Division Rules based on the applicable Medicare payment policy is discussed below.

   Review of the applicable Medicare payment policy related to status indicators for the Codes in dispute, G0237, 94640, and G0237 finds the following;

   - Procedure code G0237 with a billed date of December 14, 2016, has status indicator Q1, denoting STV-packaged codes; reimbursement for these services is packaged with the payment for any procedures with status indicator S, T or V. Primary procedure Code 26356 has a status indicator of "T" no separate payment is recommended.
   - Procedure code 94640 with a billed date of December 14, 2016, has status indicator Q1, denoting STV-packaged codes; reimbursement for these services is packaged with the payment for any procedures with status indicator S, T or V. Primary procedure Code 26356 has a status indicator of "T" no separate payment is recommended.
   - Procedure code G0237, with a billed date of December 15, 2016, has status indicator Q1, denoting STV-packaged codes; reimbursement for these services is packaged with the payment for any procedures with status indicator S, T or V. Primary procedure Code 26356 has a status indicator of "T" no separate payment is recommended.

   Review of the Medicare National Correct Coding Initiative found at www.cms.hhs.gov, for the Codes in dispute 96361, 96366 and 96374 finds the following;

   - Procedure code 96361 with a billed date of December 14, 2016, has a CCI conflict with procedure code 26356. Per CMS CCI guidelines, a modifier is allowed to override this CCI conflict however review of the medical bill finds a modifier was not used on this claim line. No separate payment is recommended.
   - Procedure code 96366 with a billed date of December 14, 2016, has a CCI conflict with procedure code 26356. Per CMS CCI guidelines, a modifier is allowed to override this CCI conflict however review of the medical bill finds a modifier was not used on this claim line. No separate payment is recommended.
   - Procedure code 96374 with a billed date of December 14, 2016, has a CCI conflict with procedure code 26356. Per CMS CCI guidelines, a modifier is allowed to override this CCI conflict however review of the medical bill finds a modifier was not used on this claim line. No separate payment is recommended.

The carrier's denial of 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated" is supported. Per the Division guidelines of Rule 134.403(d) no additional payment is recommended.

2. The remaining code in dispute is Code 26356. The fee guideline is found in 28 Texas Administrative Code 134.403 (f) (1) (A) which states in pertinent part,

   The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

   (A) 200 percent; unless

   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any 0applicable outlier payment amount shall be multiplied by 130 percent.

   - Procedure code 26356 has status indicator of T and is assigned APC 5122. The OPPS Addendum A rate is $2,395.59. This is multiplied by 60% for an unadjusted labor-related amount of $1,437.35, which is multiplied by the facility wage index of 0.8026 for an adjusted labor amount of $1,153.62. The non-labor related portion is 40% of the APC rate, or $958.24. The sum of the labor and non-labor portions is $2,111.86. The Medicare facility specific amount of $2,111.86, is multiplied by 200% for a MAR of $4,223.72.

3. The total recommended reimbursement for the disputed services is $4,223.72. The insurance carrier has paid $4,490.60 leaving an amount due to the requestor of $0.00. Additional payment is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		June 29, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.